

TOWN OF CHARLESTOWN
TAX ASSESSOR'S OFFICE
100% DISABLED TAX EXEMPTION APPLICATION
(RETURN TO THE ASSESSOR'S OFFICE BY MARCH 1ST)

APPLICANTS PERSONAL INFORMATION:

APPLICANT'S NAME: _____

APPLICANT'S BIRTHDATE: ____/____/____ MARITAL STATUS: _____ TEL NO. _____

MAILING ADDRESS: _____

911 ADDRESS: _____

QUALIFICATIONS:

THE APPLICANT MUST BE CERTIFIED BY THE SOCIAL SECURITY ADMINISTRATION AS 100% DISABLED.

DOCUMENTATION OF CERTIFICATION THAT MUST ACCOMPANY THIS FORM:

- **ORIGINAL AWARD LETTER FROM SOCIAL SECURITY ADMINISTRATION**

AND

- **ANNUAL STATEMENT OF BENEFIT FROM SOCIAL SECURITY**

ARE YOU THE OWNER OF THE RESIDENTIAL PREMISES THAT YOU
CONSIDER AS YOUR HOME? YES NO

HAVE YOU BEEN A RESIDENT AND PROPERTY TAXPAYER IN THE TOWN OF CHARLESTOWN
FOR A PERIOD OF (1) YEAR PREVIOUS TO FILING THIS FORM? YES NO

AFFIDIVIT

THE ABOVE NAMED APPLICANT, DEPOSES AND SAYS THAT THE ABOVE, WITH ATTACHMENTS HERETO, ARE TRUE AND COMPLETE, AND CLAIMS EXEMPTIONS AND/OR TAX RELIEF UNDER APPLICABLE PROVISIONS OF THE LAWS OF THE STATE OF RHODE ISLAND AND THE ORDINANCES OF THE TOWN OF CHARLESTOWN.

THE APPLICANT IS AWARE OF THE PENALTY FOR MAKING FALSE AFFIDAVIT

X _____ DATE: _____
SIGNATURE OF APPLICANT